Preferred Dentist Manual

Revised April 2010

BlueCross BlueShield of Alabama

450 Riverchase Parkway East Birmingham, Alabama 35244

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Preface

The information in this manual is provided to help you complete claim forms and conduct other administrative matters more efficiently and promptly. Keep it available as a reference.

A description of the Preferred Dentist Agreement and sample claim forms are illustrated in this manual. All procedures are designed to keep your paperwork with us uncomplicated and brief.

Note: The material in this manual is necessarily general. Nothing included modifies or changes the detailed information given in specific certificates or contracts. If there is any conflict between the information contained in this manual and the Preferred Dentist Agreement, subscriber contracts, certificates, or plans, the provisions of the contracts, certificates, or plans will supercede the information provided in this manual.

This manual is kept current by the publication, *Preferred Dental Update*. The *Preferred Dental Update* provides information such as filing procedures, benefits, and procedure codes. Also, you can find the most current version of this manual, by visiting our web page. The address is **www.bcbsal.com**.

Important Information

The following disclaimer is applicable to all telephone inquiries and automated communications systems (i.e., telephone and fax) to Blue Cross and Blue Shield of Alabama:

The information provided is only general benefit information and is not a guarantee of payment. Benefits are always subject to the terms and limitations of the plan and no employee of Blue Cross and Blue Shield of Alabama has authority to enlarge or expand the terms of the plan. The availability of benefits is always conditioned upon the patient's coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur under certain circumstances. There will be no benefits available if such circumstances occur.

Note: Please refer to our web site, **www.bcbsal.com**, for the most current benefit and policy information.

Customer Service

Dentists participating with Blue Cross and Blue Shield of Alabama's Preferred Dental Program have a dedicated telephone number to use for accessing patient eligibility, benefits, and claim status information. A Voice Response Unit (VRU) provides you this access and the VRU should be utilized to obtain such patient account information. A representative is available to assist you if the information you desire is not available through the VRU.

The Preferred Dental Program dedicated telephone number is 1-800-373-4879.

The Federal Employee Program (R prefix) has a dedicated telephone number. It is 1-800-492-8872.

Computer software created especially for dentists is available. This software allows you to obtain patient eligibility, benefits, and claim status electronically, as well as other information regarding your payments and remittances. Please contact your practice management software vendor or contact Blue Cross and Blue Shield of Alabama's Electronic Data Interchange Services department at 205-220-6899. For help with the web call 205-220-2339.

Please note that the telephone numbers listed above are for providers only. Your patients should contact Blue Cross' Customer Service Department using the telephone number listed in their benefit booklet or on their identification card.

Preferred Dentist Representative

You may reach a Blue Cross and Blue Shield of Alabama Dental Representative at 1-866-904-4130.

Suspected Fraud

As a dentist, you may encounter patients seeking medication for reasons other than their own legitimate medical needs. If you suspect fraud or abuse, please refer these concerns to Blue Cross and Blue Shield of Alabama via one of the following methods:

- The fraud hotline at 1-800-824-4391; or
- Our web site at **www.bcbsal.com**. Click on "I am a Provider" and locate the Fraud and Abuse link on the left hand side of the screen; or
- Contact your Network Services Representative.

Blue Cross accepts anonymous referrals.

Provider Credentialing

The Provider Credentialing department can assist you with registering a new provider, a change in tax identification (ID) number, a change of address, and adding a National Provider Identifier (NPI) number. **All providers must be registered by location with Blue Cross and Blue Shield of Alabama in order to submit claims for payment.** Please allow 30 days for the processing of your application.

Online Dental Provider Application
Blue Cross and Blue Shield of Alabama's Dental Provider Application is available online. To access the application, go to **www.bcbsal.com**. Click on "I'm a Provider." Under the Provider Resources section on the web page, click on "Information for Dentists." Select the "Dental Provider Application" link to access the application.

New Alabama dental providers need to register their NPI for each location at which they will be providing services by completing a Dental Provider Application. It is necessary for each location to be noted in order to be able to file claims and receive remittances. Payments will be made to the address provided on the claim. Therefore, it is important to indicate on the claim the correct address where the services were rendered.

This application is also required if an established Alabama dental provider needs to notify Blue Cross of a change to their tax identification number.

It is important to notify Blue Cross of any changes as soon as possible. Our provider file is utilized for remittance payments, Internal Revenue Service reporting, directories, and provider mailings.

If you do not have access to the Internet, complete the Provider Change Notification Form on the following page, sign and mail or fax it to the address below:

Blue Cross and Blue Shield of Alabama
Attention: Provider Credentialing
Post Office Box 362142
Birmingham, Alabama 35236-2142

Fax Number: 205-220-9545

Telephone Number: 205-220-6765

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Provider Change Notification Form

Accurate and complete information is important for providers and Blue Cross and Blue Shield of Alabama. Our provider file is utilized for remittance payments, Internal Revenue reporting, directories and publication mailings. To update your information in our provider records, complete this form, sign and mail or fax it to the address below:

Blue Cross and Blue Shield of Alabama
Attention: Provider Credentialing
Post Office Box 362142
Birmingham, Alabama 35236-2142
Fax Number: 205-220-9545

Please note that changes to the payee/remittance address require an authorized, original signature of the CEO, CFO, President, or provider.

Please indicate what information is being updated:

- ❑ **Office Address**
- ❑ **Payee/Remit/Tax Address** **(Requires authorized, original signature of the CEO, CFO, President or Provider)**
- ❑ **Correspondence Address**
- ❑ **Other (Please Specify)** _____

Provider Name _____ National Provider Identifier _____

Practice Name _____ Tax Identification Number _____

Provider E-mail Address _____

Office Address _____

City _____ State _____ Zip _____ County _____

Appt. Telephone _____ Office Telephone _____ Fax Number _____

Payee/Remittance/Tax Address _____

City _____ State _____ Zip _____ County _____

Telephone Number _____ Fax Number _____

Correspondence Address _____

City _____ State _____ Zip _____ County _____

Authorized Signature and Title _____ **Date** _____

Would you like to receive advance notifications of publications and correspondence via e-mail? _____Yes _____No

Office Manager E-mail Address(es) _____

Dental Advisory Committee

Mission

It is the mission of the Dental Advisory Committee, in accordance with the Preferred Dentist Agreement, to maintain and promote the dental care system's ability to provide quality dental care to the public.

Purpose

The Dental Advisory Committee serves as the principle liaison between Preferred Dentists and Blue Cross and Blue Shield of Alabama. The function of this committee is to provide advice and recommendations to Blue Cross concerning issues regarding the Preferred Dentist Program. Such advice and recommendations shall pertain to the practice of dentistry and the quality of dental care and may include any or all of the following:

1. Dental treatment guidelines as outlined in Exhibit B of the Preferred Dentist Agreement

2. Matters involving professional dental expertise and judgment and the quality of dental care

3. The course and direction in general of the Preferred Dentist Program in relation to professional matters involving the practice of dentistry

In the performance of its functions, the Committee shall consult with Preferred Providers, including dental/medical specialty organizations or groups as appropriate.

Composition

The Dental Advisory Committee is composed of five Preferred Dentists from different geographic areas within Alabama. Committee members are nominated and elected by the Preferred Dentist community on a rotating basis.

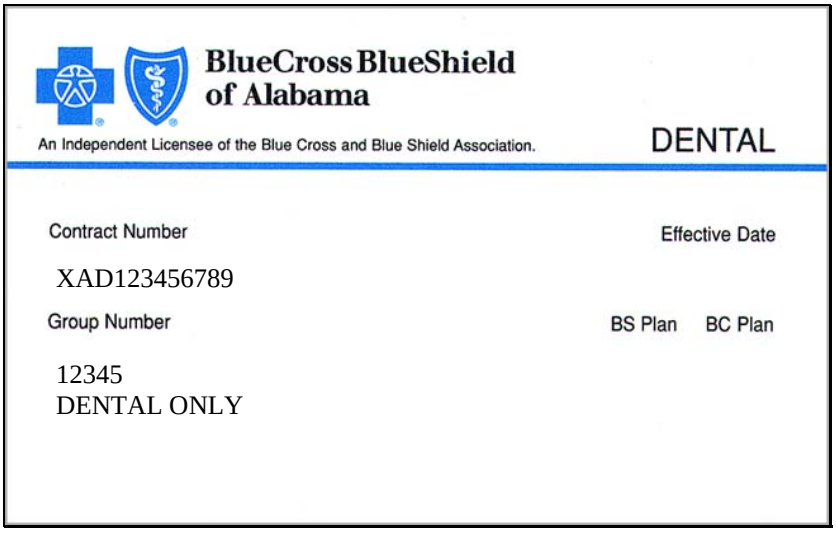
In 2009, elections will be held for districts III and IV. Be sure to watch for nomination letters and election ballots so you can participate in this important election process. Election results are effective April 1 of the election year. On the following page are the current PDP Advisory Committee members and Districts.

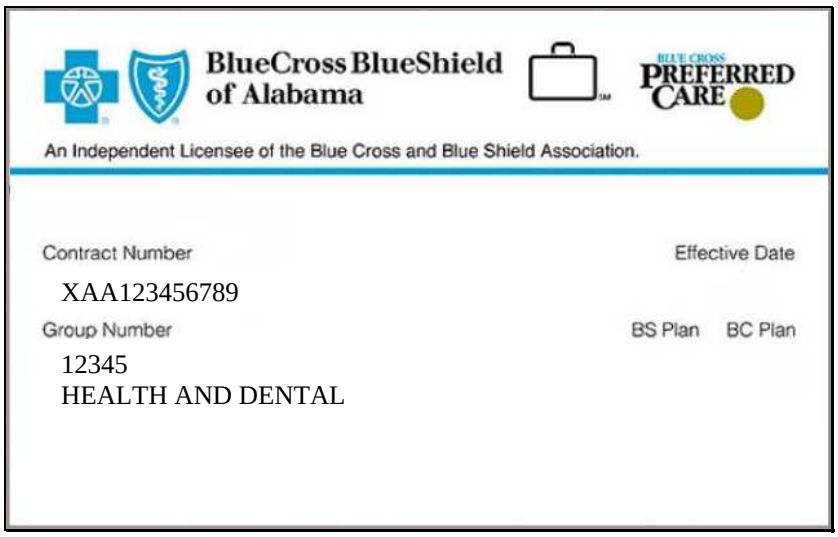
Preferred Dental Program
Advisory Committee Members and Districts

District I	Jim B. Duke, Jr., DMD 2138 Helton Drive Florence, AL 35630 256-766-5112	Blount, Calhoun, Cherokee, Cleburne, Colbert, Cullman, DeKalb, Etowah, Franklin, Jackson, Lauderdale, Lawrence, Limestone, Madison, Marshall, Morgan, Saint Clair, Winston
District II	Jack S. Smalley Jr., DMD 1100 Fairfax Park Tuscaloosa, AL 35406 205-752-3506	Autauga, Bibb, Chilton, Fayette, Greene, Hale, Lamar, Marengo, Marion, Perry, Pickens, Sumter, Tuscaloosa, Walker
District III	Stephen R. Stricklin, DMD 223 1st Street North Alabaster, AL 35007 205-663-6644	Jefferson, Shelby, Talladega
District IV	Clarence Arthur Steineker, DMD 4730 Woodmere Boulevard Montgomery, AL 36106-3065 Telephone: 334-277-5665	Barbour, Bullock, Chambers, Clay, Coffee, Coosa, Covington, Crenshaw, Dale, Elmore, Geneva, Henry, Houston, Lee, Macon, Montgomery, Pike, Randolph, Russell, Tallapoosa
District V	Frederick J. Miller, DMD 5920-B Grelot Road Mobile, AL 36609 251-343-5974	Baldwin, Butler, Choctaw, Clarke, Conecuh, Dallas, Escambia, Lowndes, Mobile, Monroe, Washington, Wilcox

Identification Cards

If a member has dental coverage, the word "DENTAL" may appear on the identification card. Contracts with an XAD prefix denote a dental contract only. Contracts with other prefixes may also include dental coverage; therefore, it is imperative to always include the prefix along with the number when filing claims. Examples of member identification cards appear below:





The identification card does not identify whether or not a patient has the Preferred Dentist benefit. The Preferred Care emblem in the upper right corner of the second card refers to the Preferred Medical Doctor (PMD) program for physicians.

By accessing our web site, **www.bcbsal.com**, automated Voice Response Unit (VRU), or other software applications you can obtain the most current benefit information on each individual contract.

Explanation of Coverage

Blue Cross and Blue Shield of Alabama's Preferred Dentist Program consists of five components forming a building block approach to dental coverage. From the components, employer groups select the dental coverage they wish to provide their employees. The minimum coverage of each group consists of coverage for diagnostic and preventive services. In addition to the minimum, groups can choose covered services, level of payment, and deductibles (e.g., 100 percent, 80 percent, 50 percent, no deductible, $25 deductible, etc.). Any out of pocket expense payable by the subscriber may be collected at the time the service is rendered.

An example of the benefits included in each of the components are summarized as follows:

Basic Services
(Oral Examinations, Prophylaxis, Routine Restorations)

Supplemental Basic Services
(Oral Surgery, General Anesthesia)

Prosthetics, Prosthodontic Services
(Dentures, Bridges)

Periodontic Services
(Periodontic Examinations, Maintenance Procedures)

Orthodontic Services
(Installation, Adjustments)

Dental Services

The following list details dental services usually covered under each of the dental riders and some limitations that are normally found on the service:

Basic Benefits

Diagnostic and Preventive

- Oral examinations (twice per benefit period)
- Dental x-rays (panoramic film each 36 consecutive months; supplemental bitewing x-rays not more often than twice per benefit period)
- Routine prophylaxis including cleaning of teeth (twice per benefit period)
- Tooth sealants for first permanent molars (tooth numbers 3, 14, 19, and 30) for children through age 13 (once per tooth each 48 months with a maximum payment of $20 per tooth)
- Topical flouride application for children under age 19 (twice per benefit period)
- Space maintainers for prematurely lost deciduous teeth for children under age 19

Other

- Restorations consisting of amalgam and/or synthetic materials
- Endodontics, including pulpotomy, direct pulp capping and root canal treatment
- Simple extractions
- Repair of dentures
- Palliative emergency treatment

Supplemental Basic Benefits

- Oral surgery consisting of fracture and dislocation treatment, diagnosis and treatment of cysts and abscesses, surgical extraction of erupted and impacted teeth and apicoectomies.

- General anesthesia when dentally necessary and rendered in connection with oral or dental surgery. General anesthesia does not include analgesics, drugs given by local infiltration, or nitrous oxide.

Prosthetic Benefits

- Dentures, full and partial
- Bridges, fixed and removable
- Single crown restorations to restore diseased or accidentally broken teeth if less expensive restorative methods are not adequate to correct the condition.
- Benefits for denture or bridge replacement shall not be provided for the situations below:
  - Any replacement made less than five years after an initial placement or replacement which was covered under the contract; or

  - Any replacement made necessary by reason of loss or theft; and

  - If, in the construction of a denture or bridge, the patient and the dentist decide on personalized restoration which employs special techniques as opposed to standard procedures, the benefits provided under this rider shall be limited to the standard procedures for prosthetic services as determined by Blue Cross and Blue Shield of Alabama.

- In all cases in which there are optional techniques of treatment carrying different fees, Blue Cross and Blue Shield of Alabama will make payment toward the treatment carrying the lesser fee.

Periodontic Benefits

Periodontic examination

- Gingivectomy and gingivoplasty
- Osseous surgery, including flap entry and closure
- Periodontal maintenance procedures
- Management of acute infection and oral lesions

Orthodontic Benefits

Orthodontic services for handicapping malocclusion, consisting of installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion. For the purpose of determining benefits available for treatment in progress at the commencement or termination of a patient's coverage, all orthodontic services shall be deemed to have been rendered on the date performed.

Coverage for orthodontic services is usually limited to patients under 19 years of age and usually has a separate lifetime maximum and deductible. Groups that cover adult orthodontics specify a different maximum and deductible in their coverage.

Submitted Charges and Fee Schedule

- Blue Cross and Blue Shield of Alabama's Preferred Dental Providers agree to accept the fee allowance or the dentist's usual charge, whichever is less, as payment in full for each dental service provided to a member. Payments shall be for the dental services provided during the member's benefit period in effect at the time a service is performed.

- Covered services provided after a member's benefit maximum has been reached are subject to the Preferred Dentist Fee Schedule. The member should not be billed for amounts above the fee schedule.

- Please remember to submit your actual charge for all services provided. You will need to make any necessary adjustments/write-offs once the claim has processed.

- The provider may bill his/her actual charge for non-covered services.

Billing for Non-Covered Services

As noted in section 4.5 of the Preferred Dental Provider (PDP) Agreement, the Preferred Dentist are responsible for notifying the patients of non-covered services or those services not medically necessary for the treatment of his/her condition.

Before performing these services, obtain the patient's signature on a written statement of non-covered services. This document should explain to the patient which services he/she will be responsible for and the amount of the charge.

The following is a suggested form that you may use in your office to notify patients of non-covered services:

As your Dentist, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your Blue Cross and Blue Shield of Alabama dental benefits contract. You are expected to pay for those services in full. Let me reassure you that I will order only treatments that I feel are necessary for your dental health and care. In addition, some services may be recommended by me for cosmetic reasons. If you have any questions about whether or not a particular service is covered by your dental benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

Patient Signature **Date** **Possible Non-Covered Services and Monies Due**

* _____

* _____

*** I have read your policy and agree to pay for the services outlined above that are not covered by my contract as indicated by my signature for each date above.**

An additional form may be drafted to address noncovered services, such as cosmetic surgery or non-medically necessary services (e.g., use of low osmolarity contrast media for non-medically indicated conditions).

Refund Requests and Provider Payments

In the event an error in payment is discovered, please refund the overpayment promptly.

When a refund request is made by Blue Cross and Blue Shield of Alabama, we may recoup such sums from the dentist or offset such sums against future payments due to the dentist. A Refund Billing Invoice will accompany the request. Typically, 3 notices within a 75-day period will be sent to the provider before we will start automatically auto-deducting the amount from the provider's payments. However, there will be certain cases when adjustments will be made without the 75-day notification.

If a refund request is not valid, you may put the refund in dispute status by calling Customer Service, by written notification or via the Internet. If your refund is found to have been requested in error, the refund will be removed from your invoice. If the refund is valid, the refund will be removed from dispute status. Refunds that are in dispute status automatically undispute at the end of six months. **Please follow up on your disputes before they are automatically deducted.**

The following methods can be used to reimburse Blue Cross and Blue Shield of Alabama:

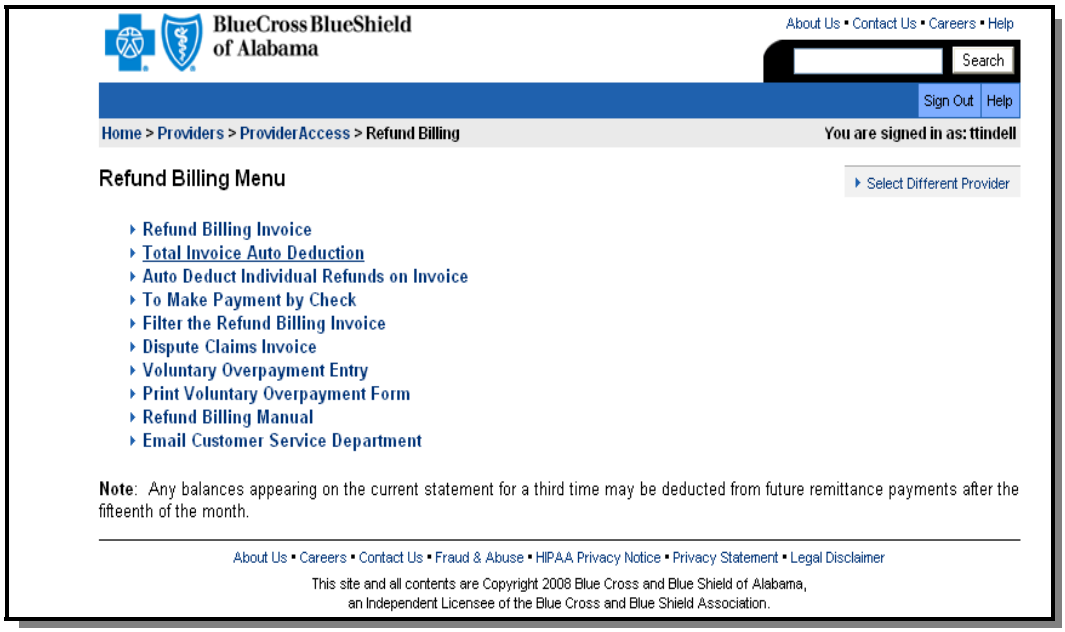
Payment by Check
When making payment by check, make checks payable to Blue Cross and Blue Shield of Alabama and attach the Return of Overpayment coupon if you are paying the **total** amount on the invoice. If you are making a partial payment, attach a copy of the invoice marking clearly the refunds that are being reimbursed on your enclosed check. By taking these actions, you can ensure that proper credit will be applied and avoid confusing situations where Blue Cross is unable to determine which accounts to properly credit.

Payment Deducted from Future Remittances Using the Return of Overpayment Coupon
If you prefer to have your payment deducted from future payments, select "Please deduct from my next remittance" on your Return of Overpayment coupon and return it in the mail. If making a partial payment, attach the coupon to the invoice marking clearly which refunds you want to be automatically deducted.

Payment Deducted from Future Remittance Using the Blue Cross and Blue Shield of Alabama Web Site
By using the web site, you may pay your entire invoice or you can select "Auto Deduct Individual Refunds on Invoice." You can use the individual feature as many times as you like. Each time you submit individual payments, the individual invoice will identify the paid refunds with a check mark. Invoices are updated the first day of each month.

Follow these simple steps to access the Refund Billing System through the Blue Cross and Blue Shield of Alabama web site:

1. Go to **www.bcbsal.com**.
2. Choose "I am a Provider."
3. Enter your Individual User ID and password.
4. Select "Payee Functions." If you have more than one Tax ID, select the one you want to view.
5. The *ProviderAccess* Menu will appear. Under Payment Information, select "Refund Billing Invoices."
6. The Refund Billing Menu will appear. Select the option that you would like to perform.



Overpayments

When there is an overpayment, either complete or partial, on the provider's remittance, the provider **should deposit the check**. The Voluntary Overpayment Return Form should be utilized to notify Blue Cross and Blue Shield of Alabama of the overpayment. Complete the form and attach a check in the amount of the overpayment only or you may submit the form via the web site to be deducted from future remittances. The Voluntary Overpayment Return Form will save time for providers and Blue Cross by reducing the need for reissued checks. Another important benefit of utilizing the Voluntary Overpayment Return Form is it ensures the provider's Information Return Form 1099 for payments is correct. The provider's check serves as support for the deduction or reduction of the revenues.

Voluntary Overpayment Return Form

Below is an explanation of how to use the form:

- Use the form to accompany any unrequested overpayments.
- Use one form per patient. More than one claim for a patient may be included on a form.
- Several forms may be combined on one check.

The Voluntary Overpayment Return Form is available on our web site at **www.bcbsal.com** under Provider Resources/Forms/Medical/Voluntary Overpayment Return.

Dental Exclusions

No benefits shall be provided under the dental plan for the following services:

- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, trustee, or similar person or group.
- Dental services for which the member incurs no charge.
- Dental services for which coverage is available to the member, in whole or in part, under any worker's compensation law or similar legislation whether or not the member claims compensation or receives benefits thereunder.
- Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
- Dental services furnished or available to a member in whole or in part under the laws of the United States (except as provided by federal law), or any state, or political subdivision thereof, or for which the member would have no legal obligation to pay in the absence of this or any similar coverage.
- Dental services to the extent coverage is available to the member under any other Blue Cross contract.
- Charges for dental care or treatment by a person other than the attending dentist unless the treatment is rendered under the direct supervision of the attending dentist.
- Charges for failure of the member to keep a scheduled visit with the dentist.
- Services or expenses of any kind, if not required by a dentist, or if not dentally necessary.
- Charges for oral hygiene and dietary information.
- Charges for plaque control program.
- Anesthetic services performed by and billed by a dentist other than the attending dentist or his/her assistant.
- Dental services rendered or furnished to the member prior to such member's effective date of coverage, or subsequent to the effective date of termination.
- Dental care or treatment not specifically identified as a covered dental expense.
- Appliances or restorations to alter vertical dimensions from its present state or restoring the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from the grinding of teeth or the wearing down of the teeth, and restoration from malalignment of teeth.
- Charges for use of any facility (including, but not limited to, a hospital) in which dental services are rendered, whether or not the use of such a facility was dentally necessary.
- Services of a dentist rendered to a member who is employed by or related to the dentist by blood or marriage or who regularly resides in the dentist's household.
- Services or expenses of any kind either (a) for which a claim submitted for a member on the form prescribed by Blue Cross has not been received by Blue Cross, or (b) for which a claim is received by Blue Cross later than 24 months after the date services were performed.

- Any dental treatment or procedure, drugs, drug usage, equipment, or supplies that are investigational.

- Services or expenses for which a claim is not properly submitted (including but not limited to, a claim with an incorrect contract number, a claim with incorrect patient information, or a claim with incomplete information on services rendered).

If there is a question about the availability of benefits, you should file a predetermination to see if Blue Cross and Blue Shield of Alabama agrees the service is dentally necessary. You can verify if a particular group requires a predetermination by accessing our web site at **www.bcbsal.com**. Not all contracts require a predetermination. Blue Cross will not provide this information unless the contract allows for it to be provided. Customer Service will be able to provide information that cannot be obtained through our Voice Response Unit or our web site.

Coordination of Benefits

Because spouses and dependents are often provided insurance coverage under multiple plans, Coordination of Benefits (COB) rules were developed to help prevent the overpayment of health and dental benefits that would occur if the two plans provided coverage independent of the other.

COB rules establish which insurance plan will pay first (the primary plan) and which will consider any remaining amounts not paid by the primary plan (the secondary plan).

Coordination of payments help reduce the possibility of members profiting from duplicate insurance coverage, as well as preventing healthcare providers from receiving duplicate payments from two insurance plans. In doing so, COB helps control the rising costs of health and dental insurance.

- If the other plan that covers a member or a member's dependents does not include “Coordination of Benefits (COB)” or a "non-duplication" provision, that plan is the primary plan.

- If both plans include a COB provision, the following conditions apply in determining the primary plan:

    1) **Non-Dependent/Dependent -** The benefits of the plan that covers the patient as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the plan covering the person as a dependent.

    2) **Dependent Child/Parents Not Separated or Divorced -** If both plans cover the patient as a dependent child, the benefits of the plan of the parent whose birthday falls earlier in the year will be the primary plan, regardless of the birth year. If the parents have the same birthday, the plan that has covered the parent longer will be the primary plan. This guideline is known as the "Birthday Rule." (If the other plan does not have the "Birthday Rule," and as a result, the plans do not agree on the order of benefits, the other plan's rule will determine the order of benefits.)

    3) **Dependent Child/Separated or Divorced Parents -** If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits for the child are determined in the order below:
        - First, the plan of the parent with custody of the child;
        - Then, the plan of the spouse of the parent with custody of the child; and
        - Finally, the plan of the parent without custody of the child.

        However, if specific terms of a court decree state that one parent is responsible for the healthcare expenses of the child, the benefits of that plan are primary.

4) **Joint Custody -** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one parent is responsible for the healthcare expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in 2 (above).

5) **Active/Inactive Employee -** The benefits of a plan that covers a person as an employee who is not laid off or retired are determined before those of a plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and as an employee. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.

6) **Longer/Shorter Length of Coverage -** If none of the above rules determine the order of benefits, the benefits of the plan that covered an employee, member or subscriber longer is determined before those of the plan that covered that person for the shorter term.

   When a member's benefits are reduced in accordance with this section during any claims determination period, each benefit will be reduced either proportionately or by any other fair manner determined by Blue Cross and Blue Shield of Alabama.

Right to Receive and Release Necessary Information

Members must supply Blue Cross and Blue Shield of Alabama the information it needs to administer Coordination of Benefits. Blue Cross must be given the right to receive and release necessary information before a member is entitled to receive benefits. When a patient has primary coverage with another insurance carrier, provide an explanation of benefits paid by that carrier when filing for secondary payment with Blue Cross and Blue Shield of Alabama. If this information is not received, your claim will be denied. Processing will continue upon receipt of the explanation of benefits from the primary carrier.

Coinsurance

Coinsurance is a percentage of covered expenses that the patient pays the dentist. (Coinsurance does not apply to groups having 100 percent coverage.) If you charge $100 for covered services performed and the patient has 20 percent coinsurance, Blue Cross pays you $80, the patient pays you $20. If the patient has a deductible and coinsurance in his benefit schedule, coinsurance begins for covered services after the deductible has been met. (Blue Cross computes the deductible and coinsurance.)

Deductible

The deductible is an amount the subscriber pays for covered services before his coverage begins. The deductible is on a benefit period basis.

The deductible must be met in a slightly different manner for each type of membership as follows:

Individual The subscriber pays you the amount of his deductible on covered services before Blue Cross and Blue Shield of Alabama benefits begin.

Family Same as Individual except that each family member must meet the deductible up through three family members. Using a $25 deductible to illustrate, a husband and wife and one child receiving dental services pay a $25 deductible each per benefit period. Partial deductibles taken on additional family members before the three member deductible maximum is met will not apply to the family deductible and will not be refunded.

FEP Dental and Oral Surgery Benefits

- Dental coverage for Standard Option and Basic Option are paid according to a schedule of allowances. Payment will be made for actual charges up to the Dental Schedule of Allowances.

- The Preferred Dentist will bill the patient the difference between the FEP Dental Schedule of Allowances and the lesser of his/her usual fee or the Blue Cross and Blue Shield of Alabama Maximum Allowable Fee Schedule for covered services.

- If the Blue Cross Maximum Allowable Charge is less than the FEP Dental Schedule of Allowances, payment will be based on the fee schedule.

Examples of FEP Benefits

1. A patient visits a Preferred Dentist and receives $100 in covered dental services. The FEP Dental Schedule of Allowances pays $60. The Blue Cross Maximum Allowable Fee Schedule allows $80. The dentist may bill the patient for the difference up to $80. The remaining amount should be written off.

2. A patient receives $100 in covered dental services. The FEP Dental Schedule of Allowances pays $60. The Blue Cross Maximum Allowable Fee Schedule allows $100. The dentist may bill the patient for the difference up to $100.

3. A patient receives $100 in covered dental services. The FEP Dental Schedule of Allowances pays $110. The Blue Cross Maximum Allowable Fee Schedule allows $90. In this case, the dentist should accept $90 as payment in full.

Dental Expense Claim

Proper completion of this claim form reduces correspondence and expedites payment for covered services rendered. The Dental Expense Claim is used for submitting a claim as well as for submitting a pretreatment estimate in cases requiring predetermination of benefits. A pretreatment estimate differs from a claim for actual services rendered in that the dates of services performed are left blank. In addition, indicate whether you are billing for services actually provided or requesting a pretreatment estimate. Not all contracts allow for pretreatment estimates/predeterminations. If it is not allowed under the contract, one will **not** be provided.

If you familiarize yourself with this manual and the American Dental Association's (ADA) *Current Dental Terminology* (CDT), it will help you in filing for benefits. Proper completion of the claim form will help us to achieve our common goal, which is prompt payment for timely professional dental care.

Dental Claim Forms

Due to an abundance of available electronic claims filing applications, Blue Cross and Blue Shield of Alabama no longer supplies paper dental claim forms. This practice became effective February 28, 1998.

For information on the electronic applications available to dentists, call 205-220-6899 and ask to speak with an EDI Services Representative or refer to the section titled "Electronic Data Interchange Services" in this manual for more information.

Completing Dental Expense Claims

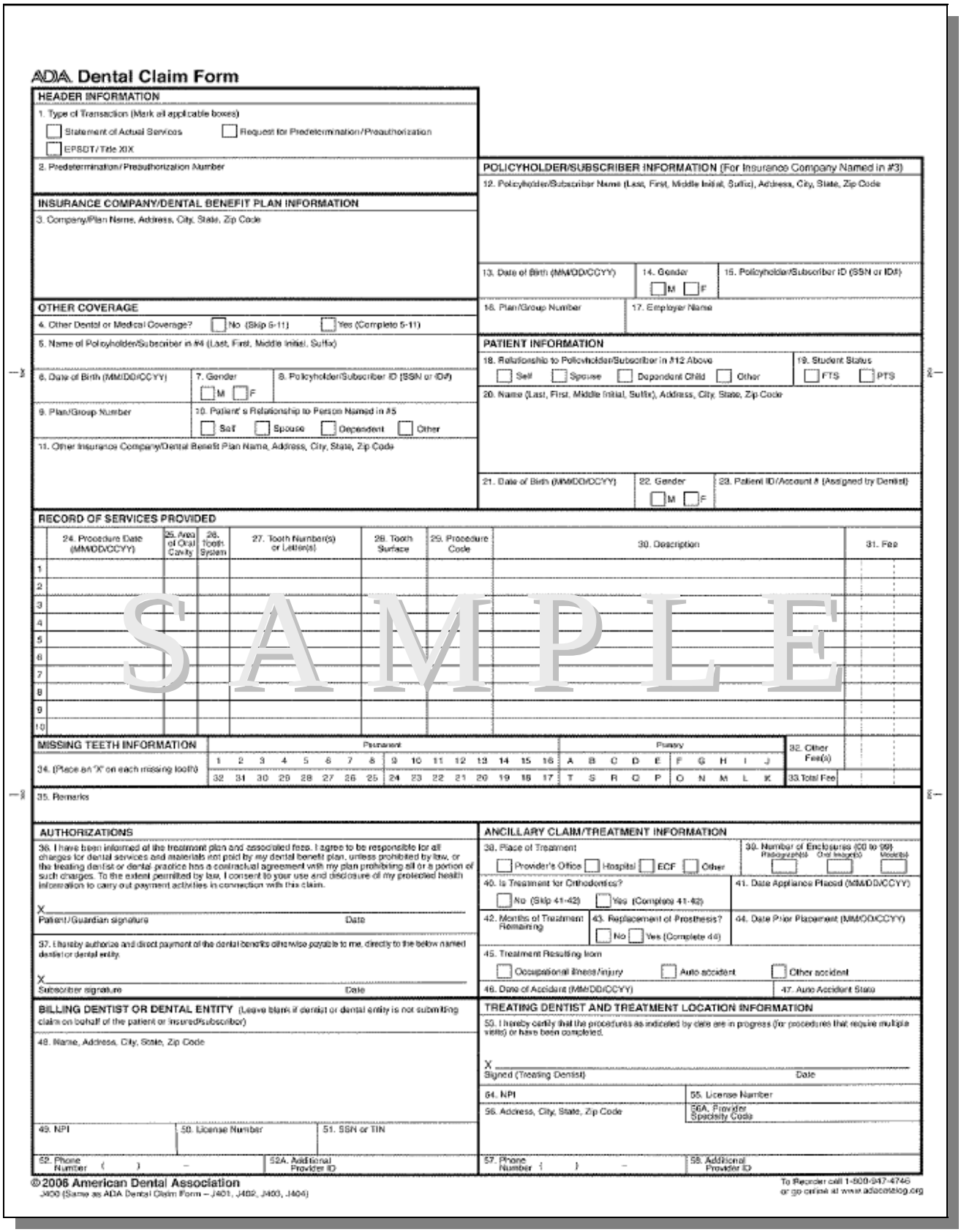
Use ADA Uniform Dental Codes only. If a code is used that is not contained in the ADA Uniform Dental Codes, include a complete written description of the procedure.

Your provider's NPI number must be listed on each claim, along with your current physical address. Your PIN consists of eight digits (510-00000 or 515-00000). The first three digits are called your **plan code**. The plan code indicates the state you are located in.

Submit a separate form for each patient, even if several members of the same family are treated.

All claims are subject to the terms and conditions of the subscriber's contract that are in effect at the time the service is rendered. Call our Customer Service Department for a determination of benefits.

All applicable areas of the dental claim form should be completed. An example of a dental claim form is on the following page.



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

SAMPLE

MISSING TEETH INFORMATION

	Permanent																Primary										32. Other Fee(s)	
34. (Place an 'X' on each missing tooth)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33. Total Fee	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiographs/PNS ☐ Oral Images(s) ☐ Models ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Medical Claims for Dental Services

To avoid problems when filing dental services under a patient's medical contract, claim form information should include primary subscriber information, secondary subscriber information (if applicable), current contract number(s) including the prefix, all patient information, date of service, tooth surface and/or quadrant information (if applicable), current ADA procedure code(s), description of service (if applicable), billed charge(s) and total amount, all current provider information and required signatures. The provider should obtain a copy of the patient's medical card and verify benefits for services being provided. File these services on a medical claim form (CMS-1500) with the correct Physicians' *Current Procedural Terminology* (CPT) codes. Following are some common medical filed dental services diagnosis codes:

520.60	Disturbances in tooth eruption
524.60	Temporomandibular joint disorders, unspecified
524.61	Adhesions and ankylosis (bony or fibrous)
524.62	Arthralgia of temporomandibular joint
524.63	Articular disc disorder (reducing or non-reducing)
524.64	Temporomandibular joint sounds on opening and/or closing the jaw
524.69	Other specified temporomandibular joint disorders
959.09	Mouth injury

If you are not sure of the CPT code to use, file with CPT code 41899 and attach a detailed narrative of the services rendered. Blue Cross encourages you to check with Customer Service to see if a predetermination can be provided. Not all contracts require or provide predetermination for services.

All x-rays submitted should have the dentist's name and NPI number, the patient's name, and contract number on them. On a case-by-case basis, Blue Cross and Blue Shield of Alabama may request x-rays or other supporting documentation related to the initial or subsequent treatment of an accidental injury to the natural teeth. Approval for payment may be based upon such information.

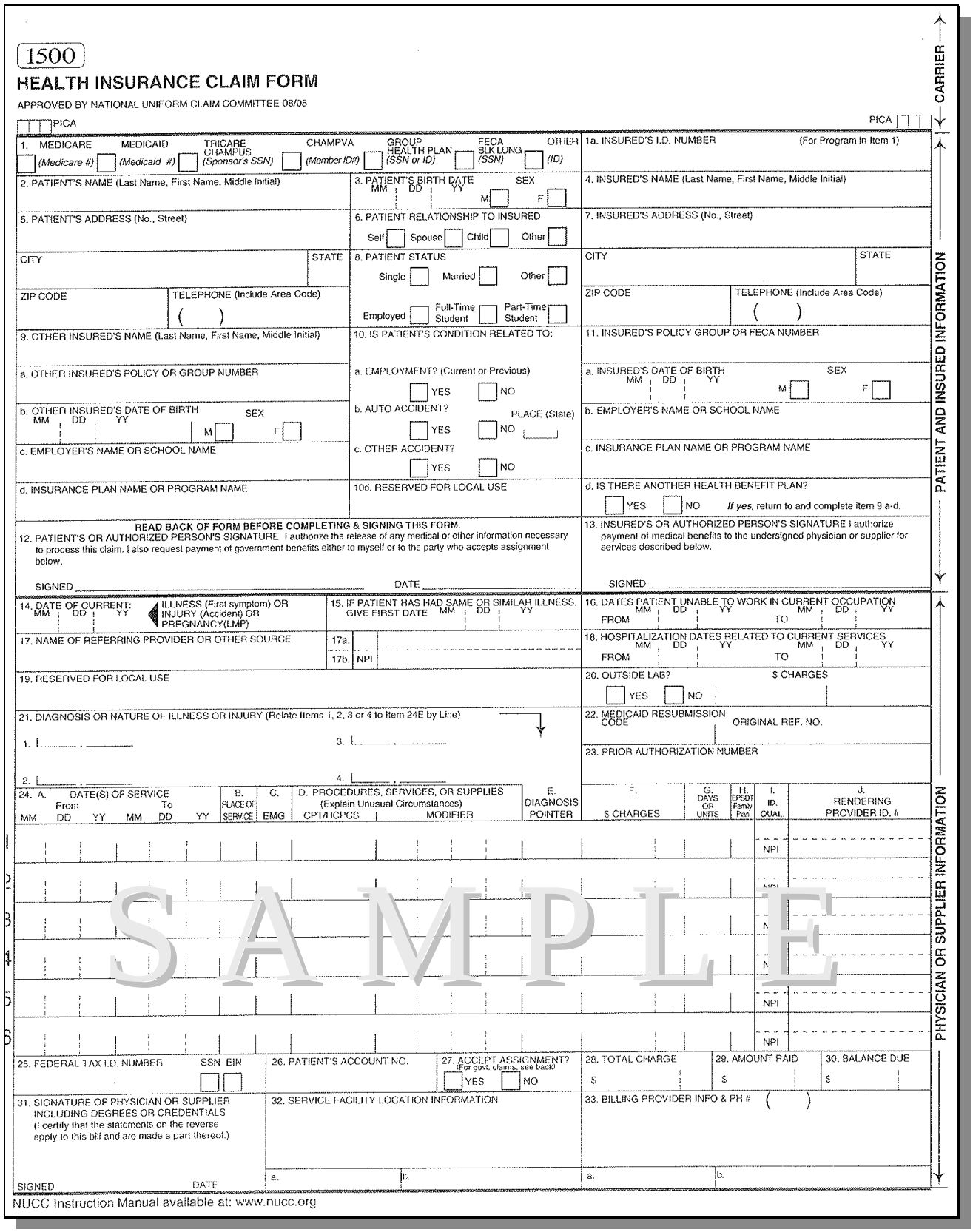
Mail the completed form and any enclosed x-rays to the following address:

Blue Cross and Blue Shield of Alabama
Medical Claims Department
Post Office Box 2294
Birmingham, Alabama 35201-2294

Mail claims for Federal Employees Program members to the following address:

Blue Cross and Blue Shield of Alabama
Post Office Box 10401
Birmingham, Alabama 35202-0401

All applicable areas of the medical claim form should be completed. An example of a medical claim form is on the following page.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

SAMPLE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

NUCC Instruction Manual available at: www.nucc.org

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Electronic Data Interchange (EDI) Services

EDI Services can assist with questions related to electronic connections to Blue Cross and Blue Shield of Alabama. Claim filing, audit report and remittance retrieval, patient eligibility and benefits information, claim status, fee schedule, and payment history data are all available in electronic format. There are many practice management software vendors that have programmed their products to interface with information housed at Blue Cross. Refer to the Vendor Functionality Matrix on our web site, **www.bcbsal.com**, to view the functionality offered by different vendor products. There are other methods available to access this data including the stand-alone software and web applications described below.

An electronic claim is any claim transmitted from a remote computer to the host computer at Blue Cross and Blue Shield of Alabama over a telephone line or Internet web application. Electronic claims may be sent directly from a physician's office or by a billing agent such as a claims clearinghouse or service bureau.

Many office computer systems offer the capability of transmitting electronic claims directly to Blue Cross. However, if your system does not currently offer this feature, electronic claims and communication specifications are available to provide your vendor with the instructions to make this possible. There is no charge by Blue Cross to transmit claims through this method.

In addition to the vendor connection with your practice management software, Blue Cross has a software product called PCEMC+. This system allows claims to be transmitted to Blue Cross as well as electronic audit reports and remittances to be retrieved. Other information relating to a provider that currently resides on the Blue Cross system can also be accessed. Examples include claim status, patient eligibility and benefits, fee schedule, and payment history. The software requires a personal computer (PC) with Windows 98 or higher plus a modem connected to a telephone line. A listing of other hardware requirements is available upon request. Blue Cross has partnered with authorized software vendors to distribute, install and maintain the PCEMC+ software in your office. This software can be used as a stand-alone product or may sometimes interface with your practice management software. If you are interested in utilizing the PCEMC+ software in your practice, you may contact any of our authorized distributors. A complete listing of current distributors can be found on our web site at:

http://www.bcbsal.com/providers/ediProviders.html

From this web page, click the PCEMC+ Vendor List link. You may contact any of these vendors directly for further information.

Another option for submitting electronic claims is an Internet application called *ProviderAccess*. It is located at **www.bcbsal.com**. This application allows for direct entry of professional and dental claims and the retrieval of electronic audit reports and remittances. Other information relating to a provider can also be accessed. Examples include claim status, patient eligibility and benefits, fee schedules and payment history. There is no charge by Blue Cross to transmit claims or retrieve other information through this method. However, a sign-in and password are required to gain access to the Internet applications. Even if you do not have Internet access in your office, there may be a way for you to utilize the Blue Cross Internet applications by dialing in directly to the Blue Cross system. For further information on this option or any other *ProviderAccess* questions, contact our dedicated *ProviderAccess* web site support line at 205-220-2339.

Statistics indicate that claims received electronically are processed in a timelier and more accurate manner than those received by mail. In addition, the system screens every electronic claim and generates an electronic report called an Audit Report. The Audit Report is designed to provide detailed feedback concerning each claims batch transmitted electronically. The first section gives a list of all claims that passed the screening and are "accepted" for processing. The next section displays the "non-covered" claims that

Blue Cross cannot process and their associated errors. This report allows for claims to be corrected and resubmitted before an erroneous payment is made.

Electronic claims are designed to help reduce the workload in your office, not only by providing more efficient and accurate methods of claims submission, but also by providing proof of receipt of every claim and the ability to follow the claims in process.

For more detailed information about electronic claims and other electronic transactions, call Blue Cross at 205-220-6899 and ask to speak with your EDI Services Representative.

Direct Deposit/Electronic Funds Transfer (EFT) - Getting Your Money Faster

Do you want to get your money up to a week earlier? Here are some frequently asked questions regarding direct deposit that may help you understand its benefits:

QUESTION	ANSWER
GETTING STARTED	
1. What is the advantage of switching to a direct deposit payment option?	Your money is in your bank account on Wednesday, the day before the actual date of the remittance. You have access to your money five to seven days earlier than if the check were mailed via the U.S. Postal Service.
2. Is there a cost or fee involved in getting set up for direct deposit?	No.
3. Are all providers eligible for EFT?	All providers in Alabama eligible for EFT. Claims for National Accounts Service Company (NASCO) groups are not paid through the EFT program.
4. Do I need to send anything with my application form?	A check or copy of a check MUST be sent with the authorization form or the EFT set-up may be delayed.
5. Do we hold payments until the EFT is effective?	No, claims continue to pay with a check until the direct deposit is effective.
6. How long before my direct deposit is in effect?	Currently, it takes about four weeks before it becomes effective.
7. How will I know when my direct deposit is in the bank?	The money is sent to your bank every Wednesday. You can check your bank account information by using your bank's online application via the Internet or by calling the bank.
8. Who do I call with Medicare direct deposit questions?	Call Medicare Customer Service at 1-877-567-7271.
9. What if I have multiple locations?	Complete an EFT (direct deposit) authorization form for each location.
10. What if I have multiple location numbers under the same tax identification number (tax ID)?	Payments will only be combined if an Organizational NPI is registered with Blue Cross. Otherwise, individual payments are made for each location number.

QUESTION	ANSWER
WHEN EFT IS IN EFFECT	
11. If a claim is paid incorrectly, will you directly charge my bank account?	No. When a refund is requested, you have 75 days to send the money or dispute the claim. If a resolution has not occurred after the 75th day, the refund automatically deducts and will reduce your next payment.
12. What if my deposit and remittance do not match?	Contact Customer Service at 1-877-567-7271. Typically, these situations occur when money is withheld for refunds or back-up withholding takes place.
13. What is needed if I want to change my bank account number or change banks?	Complete a new EFT authorization form and check the box for "Change to existing EFT account."
REMITTANCES You can view your private business paper remittances online as early as the Monday of that week's check/EFT. That means you can see your deposited amount four days before actual payment.	
14. How do I view or print my paper remittance online?	Remittances are available through the *ProviderAccess* application at **www.bcbsal.com**. Go to the **I am a Provider** section and sign-in with your *ProviderAccess* user ID and password. Once the main menu opens up, under Payment Information, simply select the **Professional Online Remittance Report** and key the remittance date you wish to view or download.
15. How do I register for *ProviderAccess*?	Go to **www.bcbsal.com** and select **I am a Provider**. Under *ProviderAccess*, choose "**Register for online access for an Individual User ID**" and follow the instructions to register.
16. If I do not know or have forgotten my password, where do I get this information?	Choose **Forgot your password?** under *ProviderAccess*. A reminder phrase will be e-mailed to the address Blue Cross has on file. If the reminder phrase does not help, contact your administrator to reset the password.
17. How long are online remittances available?	Online remittances are available for six months.

The Electronic Funds Transfer Authorization Agreement with detailed submission instructions is available on our web site, **www.bcbsal.com**. When complete, this form should be returned **with a voided check** to the address or fax number below:

Blue Cross and Blue Shield of Alabama Treasury Operations
Attention: EFT Processor
450 Riverchase Parkway East
Birmingham, Alabama 35244
EFT Processor Fax Number: 205-220-2795
Telephone Number: 205-220-4745

Filing for Reconsideration

If your claim is rejected and you wish to file for reconsideration, submit all x-rays and any **additional** information you wish to be considered to the address below:

Blue Cross and Blue Shield of Alabama
Attention: Dental Review Department
Post Office Box 830389
Birmingham, Alabama 35283-0389

Write "Do not open in the Mail Room" on the front of the envelope. Also, indicate on the claim that you are filing for reconsideration.

Things to Remember

When filing your claims, remember the following:

- If the dentist files electronically, he/she is not required to send in any x-rays unless Blue Cross requests them. If the dentist files claims on paper, he is required to send in x-rays for crowns on anterior teeth. X-rays or charts are no longer required on periodontal scaling.
- Pit and fissure sealants should be filed using Current Dental Terminology (CDT) code 01351. You should not use any of the resin restoration codes when filing for this procedure.
- If treatment is provided for an accident related condition, you must file the claim under the patient's medical contract and on a CMS-1500 claim form. Submit the date and type of accident, the specific teeth injured, the plan of treatment, x-rays, and any additional information you wish for Blue Cross to consider. See the section titled "Medical Claims for Dental Services" for more information.

Claim Filing - Most Common Errors

Following are the four most common billing errors to avoid:

- **No NPI Number** - Your complete provider identification number is necessary for accurate payment routing.
- **Invalid Contract Number** - Always put the contract number on the form **exactly** as it is on the identification card. Be sure to include the prefix. Following are examples of complete contract numbers:

  XAD999999999
  INT999999999

- **No Tax Identification Number** - Always include your tax identification number on the claim form.
- **Incorrect Group Number** - For benefits to be accurately applied, this data field must be completed. The identification card provides the group number.

When incorrect information is submitted on your claims, the claims are taken out of the regular process and payment is delayed or denied. To assist Blue Cross and Blue Shield of Alabama process your claims in an accurate and timely manner, be sure to use complete and accurate data to file your claims.

Predetermination of Benefits

This feature of the dental program is specifically designed for those situations where the subscriber may face considerable expense or a program of lengthy treatment.

Under predetermination of benefits, you can send an outline of your treatment plan (pretreatment estimate), showing the projected course of treatment to Blue Cross and Blue Shield of Alabama. To file a treatment plan for predetermination of benefits, complete the claim form (leaving out treatment dates), indicate that it is a pretreatment estimate, be sure to enclose the appropriate radiographs, and mail to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Dental Claims Department
Post Office Box 830389
Birmingham, Alabama 35283-0389

We will notify you of the services that will be considered dentally necessary.

Do not attach the predetermination of benefits response to your claim form for services provided. Complete your claim form and file it as usual.

Predeterminations are **NOT REQUIRED** for the following services:

> Examinations, x-rays, prophylaxis, periodontal scaling, root planing and curettage, sealants, amalgam and composite restorations, root canals, extractions, partial and complete dentures, posterior crowns, and orthodontic treatment.

Predeterminations are **SUGGESTED** for the services below:

> Anterior veneers and anterior crowns. Pre-operative x-rays are required for these procedures.

Predeterminations verify dental necessity only. It does not review for history of services already provided. For example, crowns are allowed once every five years. You will need to verify if benefits have been provided within that time period.

To help expedite payment, file your predetermination request and your claim indicating actual dates of services on **SEPARATE** dental forms.

X-rays
To aid in the return of your x-rays, be sure to label your x-rays with your name and address.

Remittance Statements

Blue Cross and Blue Shield of Alabama remittance checks are mailed each Thursday and will include claims processed through Monday of that week. A remittance statement will accompany each check identifying the claims processed. Should a claim be rejected, it will be indicated on the remittance statement by a rejection code. Explanations of the rejection codes will be given at the end of each remittance.

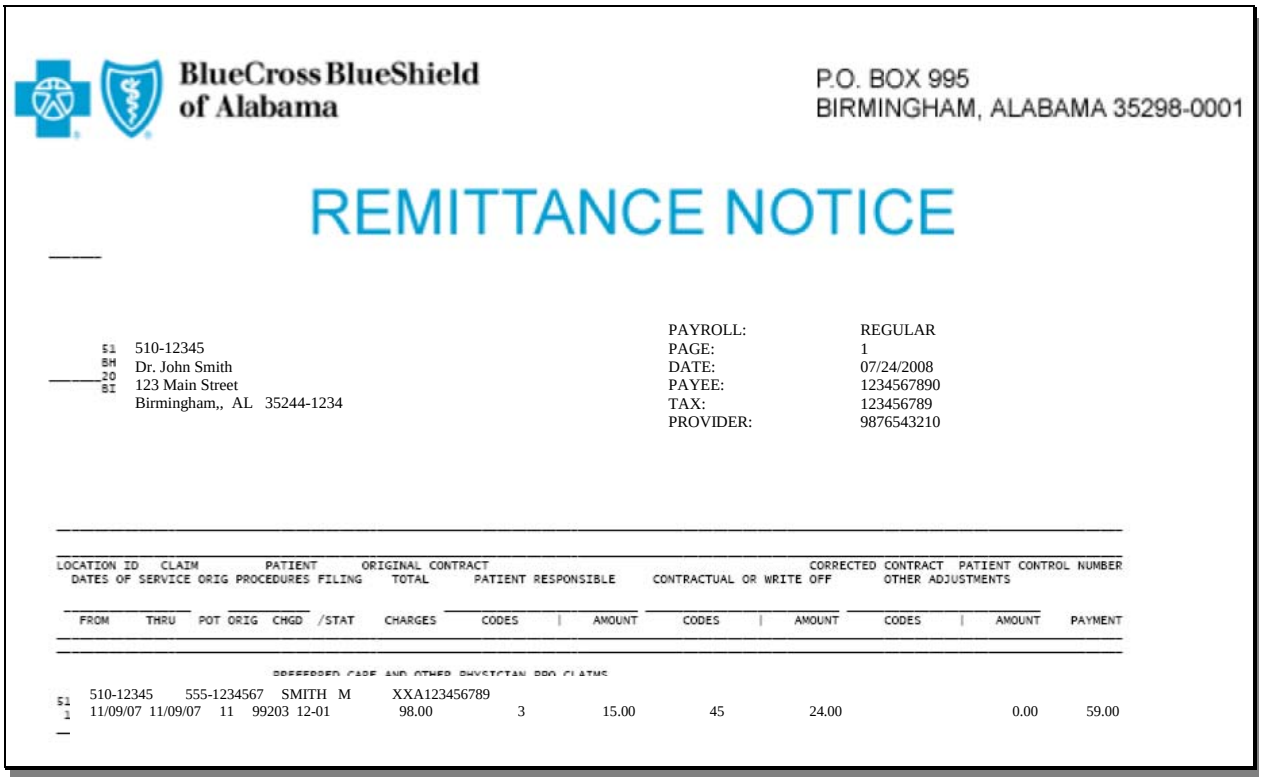
Any corrections to your remittance should be reported to our Customer Service Department. Following are possible types of corrections:

1. Payment for a patient where services were not rendered
2. Overpayment (includes payment by two insurance companies on the same service) which should not be forwarded to the subscriber
3. Payment for the wrong patient on the same contract
4. Incorrect charges submitted for services rendered
5. Double payment on the same contract and date of service

Your remittance statement will appear as illustrated on the following page. An explanation of pertinent fields on this form is provided below:

Total Charge	The total charge submitted by the dentist
Patient Responsibity	Codes Claim Adjustment Reason Codes - Go to **www.wpc-edi.com** for the complete description of these codes. Amount The percentage of covered expenses for which the patient is responsible
Contractual or Write Off	Codes Claim Adjustment Reason Codes - Go to **www.wpc-edi.com** for the complete description of these codes. Amount The amount to be adjusted by the dentist
Corrected Contract Patient Control Number	The correct non-Social Security patient identification number
Other Adjustments	Codes Claim Adjustment Reason Codes - Go to **www.wpc-edi.com** for the complete description of these codes. Amount Possible refunds or adjustment to previous payment
Payment	The amount paid to the dentist

Remember to always review your remittance statement for accuracy.



BlueCross BlueShield of Alabama

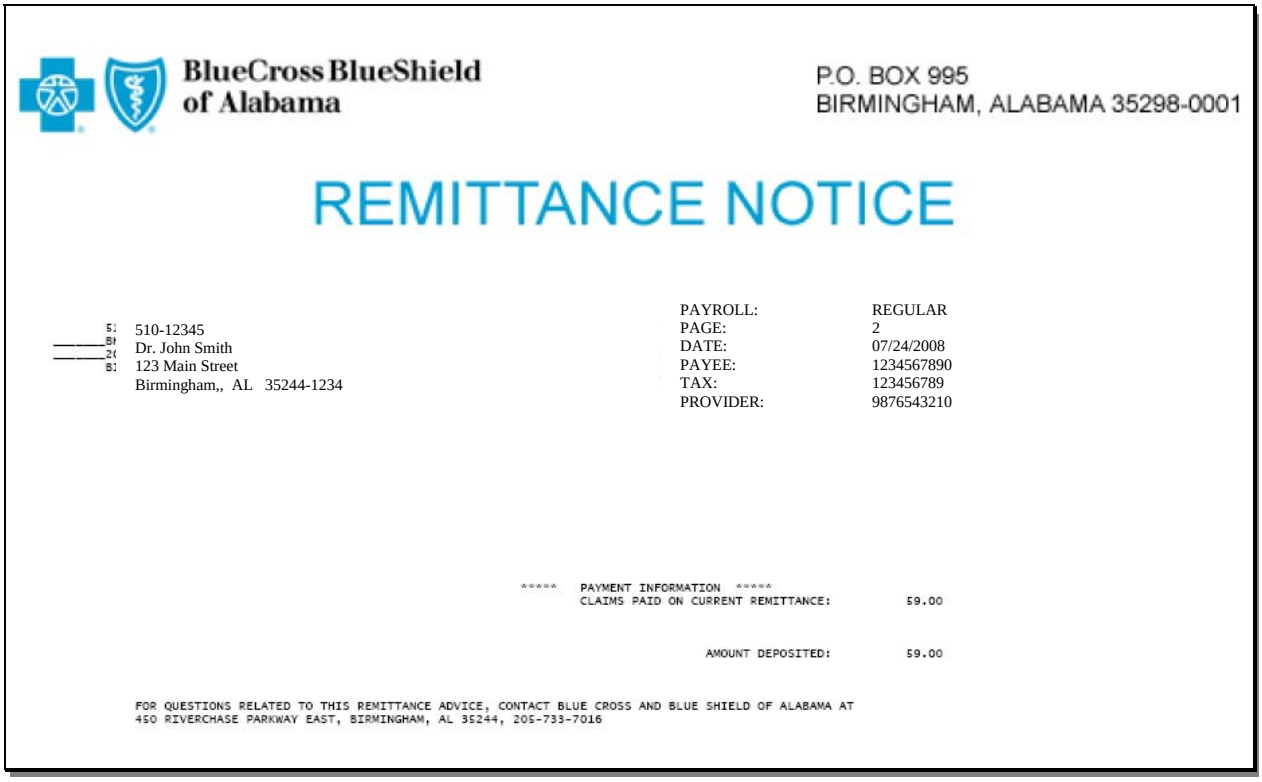
P.O. BOX 995
BIRMINGHAM, ALABAMA 35298-0001

REMITTANCE NOTICE

510-12345
Dr. John Smith
123 Main Street
Birmingham,, AL 35244-1234

PAYROLL:	REGULAR
PAGE:	1
DATE:	07/24/2008
PAYEE:	1234567890
TAX:	123456789
PROVIDER:	9876543210

LOCATION ID / DATES OF SERVICE FROM	THRU	POT	CLAIM ORIG	CHGD	PATIENT / PROCEDURES / STAT	ORIGINAL CONTRACT FILING	TOTAL CHARGES	PATIENT RESPONSIBLE CODES	AMOUNT	CONTRACTUAL OR WRITE OFF CODES	AMOUNT	CORRECTED CONTRACT / OTHER ADJUSTMENTS CODES	AMOUNT	PATIENT CONTROL NUMBER / PAYMENT
PREFERRED CARE AND OTHER PHYSICIAN PPO CLAIMS														
510-12345			555-1234567		SMITH M		XXA123456789							
11/09/07	11/09/07	11			99203	12-01	98.00	3	15.00	45	24.00		0.00	59.00



BlueCross BlueShield of Alabama

P.O. BOX 995
BIRMINGHAM, ALABAMA 35298-0001

REMITTANCE NOTICE

510-12345
Dr. John Smith
123 Main Street
Birmingham,, AL 35244-1234

PAYROLL:	REGULAR
PAGE:	2
DATE:	07/24/2008
PAYEE:	1234567890
TAX:	123456789
PROVIDER:	9876543210

***** PAYMENT INFORMATION *****
CLAIMS PAID ON CURRENT REMITTANCE: 59.00

AMOUNT DEPOSITED: 59.00

FOR QUESTIONS RELATED TO THIS REMITTANCE ADVICE, CONTACT BLUE CROSS AND BLUE SHIELD OF ALABAMA AT
450 RIVERCHASE PARKWAY EAST, BIRMINGHAM, AL 35244, 205-733-7016

Claim Adjustment Reason Codes

To get an updated list of claim adjustment reason codes, go to **www.wpc-edi.com**. On the left hand side of the page, choose "HIPAA Code Lists." From there, choose "Claim Adjustment Reason Codes."

Procedure Coding

American Dental Association

To achieve uniformity, consistency, and specificity in accurately reporting dental treatment, the American Dental Association (ADA) developed the Code on Dental Procedures and Nomenclature (Dental Code). If you would like a current copy of the ADA User's Manual you may obtain one by calling 800 947-4746 or go online to **www.adacatalog.org**.

Claims Processing Guidelines

Claims for dental services covered by a Benefit Agreement will be adjudicated according to the following guidelines except when the Benefit Agreement provides otherwise, in which case the Benefit Agreement shall prevail. These guidelines are not all inclusive. The guidelines may be changed by Blue Cross after review of the change by the Dental Advisory Committee and after giving Preferred Dentists prior notice.

Diagnostic Procedures

1. Benefits are provided for either a complete intraoral series or panographic film once every 36 months. Charges for more than one of these radiographs are not covered benefits. A second intraoral or panoramic film may be considered if provided by a different specialty within the same 36-month period.

2. Benefits for bitewing x-rays will be provided no more than twice per calendar year or twice per 12-month benefit period.

3. Panographic x-rays with or without bitewings are considered a complete series in lieu of a complete intraoral series.

4. Cephalometric films are a covered benefit only under a dental orthodontic rider.

5. Radiographs of non-diagnostic quality are not chargeable to Blue Cross or the patient.

6. A comprehensive oral examination is payable once per lifetime, per patient, per provider. However, if the patient has not been seen in three years, the claim can be filed as a new patient. Submit with CDT code D0150.

7. Periodic oral examinations are a payable benefit twice per calendar year or twice per 12-month benefit period or a combination of one comprehensive oral examination and one periodic oral examination. More than two such examinations in this time period will not be a covered benefit. The patient may be billed up to the Preferred Dental Provider fee only.

8. Pulp vitality tests are payable on a per visit basis. The patient may not be billed for any that are over the maximum.

Preventive Services

1. Benefits for prophylaxis will not be provided more frequently than twice per calendar year or twice per 12-month benefit period.

2. Charges for prophylaxis by a licensed oral hygienist are a benefit if such services are rendered under the supervision and direction of and billed by the licensed dentist.

3. Claims for prophylaxis on children 12 years of age and younger will be processed using CDT code D1120, prophylaxis for a child. All other claims for prophylaxis will be coded to adult prophylaxis.

4. Claims for the topical application of fluoride for persons **less than** 13 years of age should be filed with CDT code D1203, topical application of fluoride (prophylaxis not included) for a child.

5. Claims for topical application of fluoride for persons 13 years of age or older should be filed with CDT code 01204, topical application of fluoride (prophylaxis not included) for an adult.

6. Sealants when covered by a Benefit Agreement are benefits only for the prevention of pit and fissure type cavities and limitations specified by the Benefit Agreement.

7. Benefits for topical application of fluoride will not be provided more frequently than twice per calendar year or twice per benefit period or for persons 19 years of age or above unless the Benefit Agreement allows adult fluoride treatments.

8. Fluoride that is included in the polishing agent for dental prophylaxis is not an independent fluoride treatment and is considered to be part of the prophylaxis. In this situation only the prophylaxis is an eligible benefit and the patient may not be billed for a fluoride treatment.

9. Difficult prophylaxis should be reported as a "routine" dental prophylaxis with CDT code D1110. This procedure should not be reported as a periodontal prophylaxis, CDT code D4910, which is considered a maintenance procedure following active periodontal treatment.

10. Benefits for space maintainers used to maintain the space of prematurely lost deciduous teeth are provided only when such service is necessary to prevent future orthodontic care.

11. Space maintainers are not a covered benefit when used in connection with orthodontic care and must be passive appliances.

12. Repair of a damaged space maintainer or the replacement of a lost or stolen space maintainer is not a covered benefit.

13. Recementation of a fixed space maintainer by the same dentist or practice placing the maintainer within 12 months of initial placement may not be billed to Blue Cross or the patient.

14. Nutritional counseling for the control of dental disease and oral hygiene instruction and tobacco counseling for the control and prevention of oral disease are not covered by Blue Cross.

Restorative Procedures

1. Payment for basic restorations is intended to include all procedures related to the restoration including repairs and remakes or replacements that are necessary within one year from placement. Replacements or repairs within this time frame should not be billed to Blue Cross or the patient.

2. Benefits are provided for additional restorations on the same tooth after six months from the placement of the initial restoration if the restoration is placed on a surface that was not involved during the initial placement.

3. Payment is made for restoring a surface of a tooth once within a 12-month period regardless of the number of restorations placed or the combination of restorations placed.

4. Payment is made based upon the number of surfaces restored not on the total number of surfaces involved or restored as a result of multiple restorations. Any difference in fees as a result of the combination of surfaces or multiple restorations should not be billed to Blue Cross or the patient.

5. Restorations are a covered benefit only when the procedure is necessary to restore a decayed or fractured tooth. Restorations placed for any other reason such as abrasion, attrition, or erosion to restore the occlusion, alter vertical dimension, to close a diastema or space, or for cosmetic purposes are not covered benefits.

6. Fees for services related to the placement of restorations such as bases, liners, etching, caries removal agents, supplies and local anesthetics should not be billed to Blue Cross or the patient.

7. The cosmetic replacement of a serviceable amalgam restoration with silicate, plastic, or composite material is not a covered benefit.

8. When composite restorations are placed in posterior teeth, payment will be made on the lesser fee for a composite or amalgam.

9. When only a buccal surface is filled on a posterior tooth, service is not reduced to the allowance of an amalgam. When a buccal surface is filled with other surfaces on a posterior tooth, payment will be reduced to the allowance of an amalgam. This does not apply to teeth 5-12 or 21-28.

10. In order to bill the patient for the allowance between a composite and an amalgam on a posterior tooth, provider must have a specific non-covered services statement signed with date, service being performed, and the patient's signature.

11. Prefabricated stainless steel and resin crowns are a covered benefit on deciduous teeth and permanent teeth on patients under age 15. Prefabricated resin crowns are a covered benefit only on anterior teeth.

12. Crowns are a covered benefit only when a tooth, as a result of extensive caries involving four or more surfaces or fractures, cannot be restored with amalgam, silicate, or composite type material. Charges for temporary crowns will not be paid separately.

13. Benefits for the replacement of defective or ill fitting crowns or crowns necessary due to recurrent decay, marginal decay or additional treatment modalities placed during coverage by a Benefit Agreement are provided only after five years from initial placement.

14. Benefits are not provided for crowns to alter vertical dimension, to restore the occlusion due to attrition, abrasion or erosion, to close a diastema or for cosmetic purposes.

15. Benefits are not available to recement crowns or fix bridges within one year of initial placement. Temporary bridges are not a considered benefit and should be included in the total charges for the permanent bridge.

16. Gingivectomies, retraction or cauterization of the gingival tissue necessary to prepare the tooth for impression purposes or cementation of crowns and bridges is included in the fee for the service and should not be billed to Blue Cross or the patient.

Endodontic Procedures

1. Indirect pulp capping of permanent teeth should not be billed to Blue Cross or the patient.

2. Direct pulp capping of deciduous teeth should not be billed to Blue Cross or the patient.

3. Benefits paid for root canal therapy include all necessary clinical procedures before and after the therapy, including follow-up care.

4. The date of service for root canal therapy is the date treatment is started.

5. Root canals on deciduous teeth will be coded to the appropriate permanent tooth code for the procedure rendered and payment will be considered for that code.

6. Sedative fillings placed the same day with a covered root canal treatment or pulpotomy should not be billed to Blue Cross or the patient.

7. Root canal retreatment within a period of five years of the original root canal should not be billed to the patient or Blue Cross when rendered by the same provider or group practice that performed the original root canal. Retreatment is allowed once per lifetime.

Periodontal Procedures

1. Benefits paid for periodontal services include, but are not limited to, pre-operative and postoperative care, sutures, suture removal, periodontal dressings and replacement, and local anesthetics.

2. Routine postoperative care within 30 days of periodontal surgery should be included in the charge for surgery. Routine postoperative care rendered within this time frame should not be billed to Blue Cross or the patient.

3. Gingivectomies, gingivoplasties, gingival curettage, gingival flap procedures, periodontal scaling and root planing are payable benefits once per benefit period. Charges for more than one of these services either per tooth or quadrant are not covered benefits.

4. Benefits are provided for mucogingival surgery, osseous surgery, bone replacement grafts (single or multiple sites), guided tissue regeneration, pedicle soft tissue grafts, and free soft tissue grafts, subepithelial connective tissue grafts, and distal or proximal wedge procedures once every 36 months. Charges for more than one of these services either per tooth or per quadrant will not be covered benefits.

5. Osseous crown lengthening will be considered for payment under the periodontal rider. This service is a benefit only when it is necessary to remove bone in a healthy periodontal environment in order to place a crown. Benefits are limited to once per tooth per lifetime.

6. Periodontal maintenance procedures, CDT code D4910, are a payable benefit only for the patient who has had active periodontal treatment. This code includes services such as examination, evaluation, polishing the teeth, reinstruction on oral hygiene care, and necessary periodontal scaling and root planing.

7. Localized delivery of chemotherapeutic agents by a controlled release vehicle (i.e., actisite, into diseased crevicular tissue) is not a covered benefit. This includes actisite-periochips and Arestin®.

8. Any ADA periodontal code that does not state "per tooth" will be paid based on quadrant.

Prosthodontic Procedures

1. Replacement of existing dentures inserted under coverage by Blue Cross will be covered only if the denture is five years old and cannot be made serviceable.

2. If, in providing complete or partial dentures, the patient and dentist decide on personalized restorations and/or specialized techniques (includes, but is not limited to, precision attachments, connector bars and stress breakers), payment by Blue Cross will be made for a conventional denture only. Overdentures are considered a specialized appliance.

3. Post-delivery care is defined to include, but is not limited to, base adjustments, relief of sore spots, balancing the occlusion and relines for six months following delivery when services are provided by the same provider who delivered the denture. Charges for such services should not be billed to Blue Cross or the patient. For immediate dentures, payment can be made for one soft tissue reline from 90 days to 180 days from insertion.

4. Benefits are provided for the replacement of a bridge that was inserted under the existing Benefit Agreement if one or more abutment teeth are extracted, or if the existing bridge is five years old and cannot be made serviceable.

5. Bridges provided to fill anterior diastema are considered cosmetic.

6. Charges for tooth transplantation, endosseous, subperiosteal, and transosseous implants are not a covered benefit. Related services, repairs, complications or removal of implants are also not a covered benefit. Check contract benefits for specific benefit information.

Orthodontic Procedures

1. When billing for orthodontic services, submit your fee for the initial banding only when submitting CDT codes D8070 through D8090.

2. Monthly follow-up visits should be billed with CDT code D8670.

3. Your fee for the entire treatment plan should **not** be submitted at one time.

Oral Surgery Procedures

1. Benefits paid for oral surgery services include, but are not limited to, preoperative and postoperative care, sutures and suture removal, surgical dressings and replacement, curettage of alveolus, arch wire removal and local anesthetics.

2. Routine postoperative care within 30 days of surgery is included in the charge for the service and should not be billed to Blue Cross or the patient.

Adjunctive General Procedures

1. Limited oral evaluations (problem focused) should not be billed when rendered on the same day with a specific treatment code. Necessary x-rays to diagnose the emergency condition are a separately billable item.

Unbundled Procedures

1. The "unbundling" of charges has been recognized on a national level as a contributing factor to the increasing cost of healthcare. Examples of unbundling include the use of more than one procedure code to bill for a procedure that can be adequately described by a lesser number of codes, filing for services that are an integral part of a procedure, and filing for procedures, such as "sterilization," services, or supplies that are required in rendering dental services. When these and other unbundled claims are identified, partial denials of payment or a refund request will result.

2. Unbundled services will be considered in the appropriate code and any difference in fees should not be billed to Blue Cross or the patient.

Definitions

Benefit Period: A period of 12 consecutive months commencing on (and including) the day of the first month specified in the group contract and ending on (and including) the last day of month 12 following. Most benefit periods are on a calendar year basis.

Contract: The Group Dental Benefits contract between the employer and Blue Cross and Blue Shield of Alabama. The contract is made up of (1) the employer's Group Application for the contract, (2) the Summary Plan Description, (3) any written change to the Summary Plan Description, and (4) the Group Dental Benefits contract between the employer and Blue Cross.

Covered Dental Benefits: The amount of benefits payable by Blue Cross to or on behalf of a member who incurs expenses for dental services rendered to a member by a dentist while covered under a member's plan.

Deductible: The deductible is the amount each member is required to pay for covered dental services during each benefit period. There is a separate deductible for the employee and each covered dependent. The maximum deductible is met when three family members have satisfied their deductibles during a benefit period.

Dental Services: Such dental services, care, or treatment as specified in the member's contract for which benefits are provided, subject to the limitations, exclusions and other terms and conditions of the contract.

Dentist: One of the following when duly licensed and when acting within the scope of his/her license at the time and place where the service is rendered: Doctor of Dental Surgery (D.D.S) or Doctor of Medical Dentistry (D.M.D.)

Dependent: A person who is (1) the spouse of the employee or (2) an unmarried child of either or both, under 19 years of age (age may vary based on individual group). The term "child" shall include a legally adopted child or a child living with the adopting parents during a period of probation.

Employee: Employee of the employer who is eligible for coverage within the classification of eligible employees, as provided in the Employer's Application for this Contract and who shall have been so designated by the employer to Blue Cross.

Employee Coverage: Coverage for an employee only.

Family Coverage: Coverage for an employee/subscriber and one or more dependents.

Member: A subscriber or eligible dependent who has coverage under the contract. Also, a member is a former dependent and/or a subscriber who was not terminated for gross misconduct, who is eligible for and covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Non-Preferred Dentist: Any dentist in Alabama who has not signed a contract with Blue Cross to participate in the Preferred Dentist Program (PDP).

Payment of Benefits: Benefits are provided according to the Blue Cross and Blue Shield of Alabama PDP fee schedule for covered dental services. The program pays the charge of the dentist for a covered service, but not more than the usual charge or the PDP fee schedule as determined by Blue Cross and Blue Shield of Alabama.

Preferred Dentist Program (PDP): A program whereby dentists in Alabama with which Blue Cross has a contract for the furnishing of dental services paid according to an agreed upon fee schedule.

Preferred Provider: Any provider of dental care services or supplies (such as a Preferred Dentist) in Alabama with which Blue Cross has a contract for the furnishing of dental services and supplies to members entitled to benefits under the Preferred Dentist Program. A Preferred Dentist shall be considered Preferred at all practice locations.

Subscriber: The employee whose application for coverage under the contract is made and accepted.

Treatment Plan: A written report indicating the recommended treatment of any dental disease, defect or injury for a member prepared by a dentist as a result of any examination made for a member while coverage under this contract is in effect for the member. Blue Cross will verify the availability of benefits, under the contract, determine that the member's coverage is in effect, and that the proposed services, as indicated by the treatment plan and other data submitted, are to be covered under the contract.